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Litigating Nursing Home Wandering Cases

This article defines the term wandering and provides prevalence estimates of wanderers within nursing homes nationwide. It addresses the standard of care applicable to wandering cases and reviews court opinions that consider whether the nursing home was on notice of a resident's known tendency to wander. It discusses discovery in wandering cases and concludes with practice tips.

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Lillian Huffman, a nursing home resident who suffered from dementia, allegedly had a history of wandering out of the facility. In the early morning hours of January 19, 1997, she walked outside into temperatures hovering in the single digits. Another resident spotted her at 7:35 a.m. in the facility's garden. Lillian was pronounced dead less than two hours later from hypothermia due to cold exposure.[1]

A demented 69-year-old survivor of seven strokes wandered away from a Florida nursing home and drowned.[2]

A resident left his Arkansas nursing home in a wheelchair, without being noticed by facility staff, and subsequently was struck by a pickup truck.[3]

A 68-year-old mentally incompetent resident wandered away from a nursing home and was struck and killed by a van driven by his daughter. Staff involved in the care and supervision of the deceased were aware of his confused mental state and propensity to wander off the grounds. Nevertheless, they had turned off the home's alarm system because the noise was annoying, even though the physical layout of the building prevented observation of the front door by staff members at the nursing station, which also was sometimes left vacant.[4]

Nursing home residents may be injured as a result of wandering around in the nursing home or wandering away from the facility itself.[5] "The most common injuries incurred by residents outside of the nursing facility are from exposure to the elements[6] or from being

struck by a moving vehicle."[7] Some residents wander away and disappear never to be found.[8]

What is Wandering?

Wandering is one of the most intriguing, potentially hazardous, and least understood of dementia-related behaviors.[9] The term wandering has been poorly, ambiguously, and inconsistently defined.[10] "Wandering is a purposeful behavior that attempts to fulfill a particular need (from the context of the wanderer).[11] It is initiated by a cognitively impaired, disoriented individual and is characterized by excessive ambulation[12] that often leads to safety and/or nuisance related problems."[13] It has a seemingly aimless, lapping, or random quality or pattern.[14] Wanderers may misperceive environmental limits (physical barriers, such as furniture, for example).[15] Their behavior reflects spatial disorientation or navigational deficits (such as getting lost, impairment in learning new or following old routes, and shadowing others).[16] As a result, wanderers place themselves in hazardous situations that cognitively intact persons would avoid.[17]

For the purposes of litigation, the wandering of a nursing home resident should be thought of as behavior that should be eliminated or reduced and, at all times, safely accommodated.

Prevalence of Wandering

Prevalence estimates of wandering vary widely given the inconsistent definition of wandering and diverse clinical samples (for example, one study considers wandering behavior only in persons with dementia while another study concentrates on persons with mixed cognitive problems).[18] The proportion of ambulatory, demented nursing home residents who wander is likely higher than the unweighted mean of thirty-one percent derived across studies.[19]

Standard of Care

At a minimum, a nursing home must identify wanderers, develop prevention programs and activities, keep the facility safe, and have a swift, comprehensive, facility-wide method to mobilize staff to look for a missing resident. Expert testimony often is critical to successful litigation against nursing homes. In practice, physician, nurse, and nursing home administrator experts testify about the resident's wandering behavior and the applicable standard of care.

Known Tendency to Wander

Decisions Against Facility

Knowledge by the nursing home of special facts is more likely to give rise to liability. Recovery has been allowed, for example, where the nursing home was on notice of a resident's known tendency to wander.[20] If the nursing home knew the resident was a wanderer, and failed to take proper precautions, the facility may be found liable for any subsequent injury or death.[21] For example, in *Golden Villa Nursing Home v. Smith*,[22] a motorcycle struck a nursing home resident who left the facility and wandered onto a highway.[23] The Texas Court of Appeals affirmed a verdict against the facility, finding that the resident's long history of wandering put the home on notice of the resident's known tendency to wander.[24] In *Booty v. Kentwood Manor Nursing Home*,[25] the Louisiana Court of Appeal affirmed a verdict against a nursing home in a case where a resident wandered out of the facility and fell on the front step fracturing his hip. The court noted that staff retrieved the resident twice from outside the facility on the night he was injured.[26] In *Fields v. Senior Citizens Center*,[27] the Louisiana Court of Appeal affirmed a wrongful death verdict involving a resident who wandered away from the facility and was struck by a car reasoning, in part, that the nursing home knew that the resident tended to wander. In *McGillivray v. Rapides Iberia Management Enterprises*,[28] the Louisiana Court of Appeal again affirmed a verdict against the nursing home finding that the facility knew that the resident was at risk for wandering. In *McGillivray*, the plaintiffs informed the nursing home administrator that their sixty-nine-year-old father who was suffering from diabetes, hardening of the arteries, and other cardiovascular problems was being transferred from another nursing home because, "[h]e had been getting out a lot."[29] Sixteen months later, in the early hours of a morning during which the outside temperature was forty-two degrees, the decedent wandered out of the facility wearing only light sleeping attire, and died a few minutes later of a heart attack. The judge concluded that:

> [T]he fact that this patient, who was elderly and had serious health problems and *had a habit of wandering off* and for whom the facility had authorized the use of restraints, was simply able to walk out of [appel-

> lant's] facility . . . clothed in light sleep attire on this cold night without anyone seeing him or being aware that he had exited the building, constitutes negligence on the part of the [appellant].[30]

Decisions Favoring Facility

In *Murphy v. Allstate Insurance Co.*,[31] the Louisiana Court of Appeal reversed a verdict against a nursing home finding that the facility had an adequate staffing level and was unaware of the resident's tendency to wander.

Discovery in Wandering Cases

How Does the Facility Identify Wanderers?

According to federal regulations, a nursing home must conduct a comprehensive, accurate assessment of each resident's needs "within 14 calendar days after admission"[32] and "not less than once every three months"[33]thereafter, unless there is "a significant change in the resident's physical or mental condition."[34] One of the primary aims of a clinical assessment is to recognize persons at risk for wandering, and to discover causative factors (such as overstimulation, boredom, restlessness, loneliness, stress, desire to feel useful, or prior life patterns).[35] Did the facility that is the subject of litigation take appropriate measures to identify the wandering resident? Was their assessment accurate?

Did the Facility Develop a Care Plan for the Wanderer?

The resident's assessment is used to develop, review, and revise the resident's plan of care. Within seven days after completing the assessment,[36] an interdisciplinary team[37] must "develop a comprehensive plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, mental, and psychosocial needs as identified in the comprehensive assessment."[38] The care plan is reviewed and revised every ninety days, unless a significant change occurs in the resident's condition or identified needs.[39]

The care plan must detail "[t]he services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being[.]"[40] Inaccurate assessments result in inaccurate resident care plans. The resident's care plan should reflect staff knowledge of the resident's wandering behavior. In litigation, this document can be used to demonstrate that the staff knew that the resident was a wanderer and, despite this knowledge, failed to follow the established care plan and failed to keep the resident safe.

What Programs Address the Wanderer's Needs?

Federal regulations demand that Medicare and Medicaid-certified nursing homes "provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident."[41] Providing an active and stimulating daily routine of recreational programming, intended to safely exhaust the resident, can be an effective method in the care of wandering residents.[42]

What Behavioral Interventions Were Used?

Behavioral interventions have been used to help manage wanderers. For example, the intrusive wandering behavior of one demented woman was handled by trading rooms with another resident to accommodate the wanderer's travel patterns.[43]

Was the Wanderer's Environment Free of Accident Hazards?

An important issue is whether the nursing home took all possible steps to protect the wandering resident from hazards. By law, the facility must ensure that "(1) The resident environment remains as free of accident hazards as is possible; and (2) [e]ach resident receives adequate supervision and assistance devices to prevent accidents."[44] This regulatory section applies to wandering cases.[45] Consider, for example, whether the facility provides safe wandering areas (that is, areas that are free of environmental hazards and obstacles) equipped with door and/or perimeter monitoring systems to prevent exit from the safe area.[46]

Other environmental modifications used to discourage wandering into inappropriate areas and/or exit from the facility include, but are not limited to the following:[47]

- mounting full-length mirrors on doors and exits;
- camouflaging doors with wallpaper or window treatment;
- creating a grid with masking tape on the floor in front of a doorway;
- placing a stop sign on door;

- attaching an eighteen-inch wide barrier strip or cloth panel across a doorway with Velcro; and
- installing an alarm system.

Does the Nursing Home Have Specialty Units?

The confused, ambulatory resident's safety must be insured while their personal freedom is maintained. This delicate and often precarious balance is the focus of a growing number of specialty care units created within nursing homes to address the unique needs of residents with Alzheimer's disease, for example, who are among the most likely to wander.[48] The physical environment of these units is specially designed for wanderers.[49] Does the defendant nursing home have a specialty unit devoted to the care of residents who wander, are agitated, or are demented? A number of states, for example, regulate special care units for residents with Alzheimer's disease.[50]

Are There Any Prior Incident Reports Involving Other Wanderers?

Incident reports can be useful in demonstrating a pattern of (mis)conduct on the part of the facility and may be used to justify an award of punitive damages.[51] Evidence of similar incidents rebuts claims that the facility was unaware of wandering problems. In an action against a personal care home for negligent supervision of a resident with Alzheimer's disease arising from an incident in which the resident wandered unsupervised into the cold and suffered hypothermia, the Court of Appeals of Georgia found that the plaintiff was entitled to discovery of records of other incidents and accidents or sudden adverse changes in the health of other residents that the home was required to keep pursuant to regulations of the State Department of Human Resources.[52] The court reasoned that the records were "highly relevant concerning the true scope of the [negligent supervision] problem and the extent to which punitive damages might be required to punish or deter."[53]

How Does the Facility Protect Against Residents Leaving the Facility Unnoticed?

No cognitively impaired ambulatory nursing home resident should be allowed to leave the facility without staff knowledge.

> *In one disturbing incident last summer, a nursing home resident was found hobbling down Route 28 with his walker at 3:05 a.m. Several nursing assistants were on duty that night, but apparently none of them noticed the man leaving.*[54]

Is keeping track of a wandering resident a shared responsibility or a nursing responsibility?[55] What plan does the nursing home have to respond to wanderers leaving the facility without notice? Does the facility have a missing person policy?

Are There Any Entry and Exit Alarm Systems?

Some nursing homes have alarmed entry and exit systems and/or bed alarms to detect residents who are prone to wandering off the nursing unit or out of the facility.[56] For example, in *Booty v. Kentwood Manor Nursing Home*[57] and *Fields v. Senior Citizens Center of Coushatta*,[58] the nursing homes had alarm systems intended to warn staff that someone was leaving the building, but the alarms were off at the time of the respective incidents. In *Altenheim German Home v. Turnock*,[59] the Seventh Circuit notes that the Illinois Department of Public Health ordered the nursing home to "equip all the exterior doors of the facility with alarms" after several incidents in which demented residents had wandered off.[60]

Request a schematic floor plan of the building that includes the location and type of each installed alarm showing, for example, alarms that sound at the unauthorized opening of the door, door ajar alarms (that is, alarm sounds if door is propped or blocked open),[61] or alarms that sound when another door alarm has been shut off.

Are There Any Wandering Control Devices?

Wandering control devices work similarly to department store tag devices. An identification tag placed on the resident's wrist or ankle activates door detection sensors when the resident approaches the exit, thus setting off the alarm.[62]

In *Ragle v. Beverly Enterprises, Inc.*,[63] a national nursing home chain was accused of negligence in the death of a resident who wandered away from the facility and died of hypothermia shortly after being found.[64] The resident had been fitted with a WanderGuard bracelet that sets off an alarm when the wearer attempts to exit the facility.[65] The resi-

dent's spouse helped remove the bracelet.[66] Their daughter sued charging the nursing home was responsible for her father's death.[67] A St. Louis jury awarded some damages to the plaintiff—$100 reduced to $1 on the finding that the resident was ninety-nine percent responsible for his death.[68]

In *Hamilton v. First Healthcare Corp.*,[69] "a demented sixty-nine year-old man who had survived seven strokes wandered away from a nursing home and drowned in a pond."[70] The nursing home knew that the resident was a wanderer and, in fact, had reports documenting that the resident had wandered away from the facility three times over a twenty-one-month period.[71] Defense counsel unsuccessfully argued that the resident's "remaining dignity and independence stopped the home from making him wear a wander guard."[72] The nursing home never asked the resident about wearing an alarm and his widow testified that when she brought the subject up after an earlier wandering incident, her husband said he would wear one.[73]

In Michigan, a ninety-four-year-old nursing home resident froze to death after wandering away from the defendant nursing home despite a monitoring device attached to the decedent. The parties settled for $200,000 with the manufacturer of the monitoring device paying $20,000 and the nursing home paying the remainder.[74]

There are bed and chair alarm systems as well as resident-attached devices that sound upon movement.[75] For example:

- Ambularm is a small plastic-enclosed unit that attaches to a person's upper leg with a fabric band. An alarm sounds when the resident's leg shifts from a horizontal to a vertical position.[76]
- WanderGuard's Tabs Mobility Monitor consists of a sensor unit mounted to a bed headboard, chair, or wheelchair and a garment clip attached to the resident's clothing. When the person attempts to leave the bed or begins to stand, the cord is pulled from the sensor unit and an alarm (audio and visual) sounds.[77]
- RN+ OnCall Bed Patient Monitoring System involves a signal unit mounted on a bed headboard, a pressure sensitive pad placed beneath the bed linens, and a receiver console located at the nursing station. An alarm (audio and visual) sounds when the resident attempts to leave the bed.[78] Similarly, RN+ offers a signal unit that can be mounted on a chair or wheelchair with a pressure sensitive pad placed on the chair seat.[79]

Obtain Alarm Information

Request information concerning the alarm's installation, operation, servicing, and support. A checklist of possible areas of inquiry appears in Table 1.

Table 1. Alarm Information Checklist

- ☐ Who manufactured the alarm system?
- ☐ What is the name of the manufacturer's representative?
- ☐ Who is the facility's contact person with the manufacturer?
- ☐ Any files regarding the purchase of and the servicing of the alarm system?
- ☐ Did the manufacturer install the alarm system? An outside contractor? Facility personnel?
- ☐ Did the facility purchase support for the product from its manufacturer?
- ☐ How frequently does the manufacturer visit the facility for product support or maintenance?
- ☐ Did the manufacturer provide training for staff and/or nursing home administration?
- ☐ Did manufacturer instructions governing alarm use accompany its purchase and/or installation?
- ☐ How does the alarm work?
- ☐ How is the alarm set or reset (for example by code or by key)?
- ☐ When is the alarm on, and when is it off?
- ☐ Who is responsible for turning the alarm(s) on and off?
- ☐ Check carefully to determine if any of the alarms are turned off because staff find alarms annoying as they move within or without the building (this is a very common occurrence).
- ☐ What type of signal does the alarm emit?
- ☐ How loud is the sound?
- ☐ Does the alarm manufacturer maintain records as to what nursing homes use their product?
- ☐ Does the manufacturer keep records on how frequently the alarm systems are serviced?

Policy and Procedure Governing Staff Response to Alarms

Obtain copies of policy and procedure manuals in use during the time the plaintiff was a resident at the institution, specifically those governing staff response when an alarm sounds. Do staff members deactivate the alarm(s) for their convenience?

Early in the morning on January 23, 2000, eighty-one-year-old Isabelle Snyder wearing a shirt,

thin gown, and slippers wandered out of the nursing home into sixteen degree temperatures.[80] She apparently froze to death, "a quarter-inch of snow on her body and a stream of frozen mucous hanging from her nose."[81] The morning Snyder died, nurse's aides didn't make the required rounds, and staffers failed to investigate an alarm that went off on one of the doors leading outside.[82] Snyder had tried to leave the home at least fifteen times and three times made it outside before the staff noticed.[83]

In *Conley v. New Haven Nursing Home, Inc.*,[84] the jury returned a modest $50,000 verdict in the case of a nursing home resident who died of injuries sustained when she fell down an embankment after she wandered away from the facility. The defendant nursing home failed, among other things, to "respond to an alarm that went off after the decedent walked out of the facility."[85]

Was Any In-Service Training Offered on Alarm System or Wandering Control Devices?

Did facility staff and nursing home administration receive training regarding the alarm system and/or wandering control devices? Is such training part of every new employee's orientation? Were residents and their family members educated about the alarm system and, if appropriate, any wandering control device? Review schedules for, and examine attendance sign-in sheets of, in-service training sessions that cover this subject. Secure copies of all handouts or other documents distributed at the training programs or as part of a new employee's orientation.

Does the nursing home rely on a videotape presentation to train staff regarding alarm systems and elopement devices? If yes, obtain a list of training videotapes, the log of who has requested them, and copies of handouts that accompany the videotape. Remember to watch the videotape(s).

Practice Tips

Identify and Contact Wander Security System Companies

Identify companies that manufacture alarm systems and wandering control devices.[86] Accomplish this through a literature search, remembering to tap vast Internet resources. Contact information is provided for select companies in Table 2. Obtain product brochures from as many companies as possible. The promotional brochures, as well as the inserts that accompany the product itself, set out standards and emphasize that staff awareness, commitment, and understanding of the technology determines the effectiveness of the wanderer security system.

Table 2. Alarm Manufacturer Contact Information (product identified in parenthesis)

Alert Care, Inc. (Ambularm)
591 Redwood Highway, Ste 2125
Mill Valley, CA 94941
(800) 826-7444
www.alertcareinc.com

RF Technologies, Inc. (Code Alert)
3125 N. 126th Street
Brookfield, WI 53005
(262) 790-1771
www.CodeAlert.com

Senior Technologies (WanderGuard Departure Alert Systems)
1550 N. 20th Circle
Lincoln, NE 68503
(800) 824-2996
www.seniortechnologies.com

Tactilitics, Inc. (RN+ Systems)
4760 Walnut Street, Ste. 105
Boulder, CO 80301-2561
(800) 598-1868

Review Wander Security System Company Records

Many companies maintain records as to what nursing homes have installed their devices and how frequently those devices have been tested or serviced.

Consider Using Expert Testimony Regarding Alarms

Expert testimony may be required to establish whether the standard of care requires alarm installation. Frequently, the nursing home medical director, attending physician or nursing home staff persons will agree in deposition that the standard of care requires alarm precautions in situations involving a wanderer. For example, in *Rosemont, Inc. v. Marshall,*[87] a mentally incompetent resident escaped from a physical restraint and wandered out

of the nursing home through an unlocked door that had no alarm, fell down an embankment, broke her shoulder, and died four days later. The Alabama Supreme Court was unable to find the nursing home negligent because the plaintiff failed to present expert testimony on whether it was standard procedure to install alarms on nursing home doors.[88]

Conclusion

The successful litigation of a nursing home wandering case depends on addressing the standard of care applicable to the case at hand and the nursing home's knowledge of the resident's tendency to wander. Researching the nursing home's procedures and practices, together with any wander detection equipment (or the lack or failure thereof) is crucial to making the case against the nursing home when their negligence has caused a resident's death.

Endnotes

1. *See* Banks v. American Baptist Homes of the Midwest d/b/a/ Baptist Retirement Home, No. 97-L-03256 (Cir. Ct. Cook Cty. Ill., settlement July 1999); *See also Wandering Death of Resident Leads to $950,000 Settlement*, 1 NURSING HOME LEGAL INSIDER 4, 4 (Oct. 1999) (discussing *Banks*).

2. *See* Hamilton v. First Healthcare Corp., No. CL97-1621 (Cir. Ct. Palm Beach Cty. Fla., Feb. 11, 1998).

3. *See* Bailey v. Rose Care Ctr., 817 S.W.2d 412 (Ark. 1991).

4. *See* Fields v. Senior Citizens Ctr., Inc. 528 So.2d 573 (La. Ct. App. 1988). *See also Judicial Review of Damage Awards in Medical Liability Actions,* 11 VERDICTS, SETTLEMENTS & TACTICS 124, 125 (May 1991) (discussing *Fields v. Senior Citizens Ctr.* $200,000 award to resident's widow, $92,000 award to daughter who drove the van that struck and killed her father, and $7,500 award to siblings).

5. *See* Janet Shafer Boyanton, *Nursing Home Litigation: An Emerging Field for Elder Law*, 10 THE ELDERLAW REPORT 1, 5 (Apr. 1999). *See, e.g.*, Gema Daley, *Nurse Home Probe Urged*, NEWCASTLE HERALD, Feb. 14, 2000, at 7, *available in* 2000 WL 6354026 (inquiring into two wandering incidents involving the same nursing home—the death of an eighty-year-old resident suffering from dementia who left the facility and was missing for twelve days before his body was found in a bush 300 meters away and an incident five years earlier where a frail eighty-four-year-old, also with dementia, left on a rainy night and died less than a week later of pneumonia); *Nursing Home Death*, ASSOCIATED PRESS NEWSWIRES, Jan. 28, 2000 (detailing a Maine Department of Human Services investigation into the death of a seventy-eight-year-old woman found outside the facility); Kurt Erickson, *Two Nursing Homes in Area Fined by State*, PANTAGRAPH BLOOMINGTON, Jan. 19, 2000, at A6, *available in* 2000 WL 7786702 (stating that Illinois Department of Public Health fined a nursing home $10,000 for allegedly failing to supervise a ninety-five-year-old woman who wandered away from the facility and was found "lying on her back, with cuts on her nose and bruises on her face and a wrist"); Estate of Taylor v. Homestead Nursing Homes, CJ-98-1322, 1999 WL 1333693 (Tulsa Cty., Okla., Oct. 1999) (awarding $10,000 in case of an eighty-nine-year-old nursing home resident with Alzheimer's disease who suffered a closed head injury after wandering out of the facility and falling off a retaining wall); Schiffman v. Delaware First Healthcare Corp., No. 692 1738, 1993 WL 819825 (Alameda Cty. Calif. Super. Ct., settlement May 1993) (reporting $300,000 settlement where fully ambulatory nursing home resident suffering from Alzheimer's disease wandered away from the nursing home ten times within twenty-three days only to fall into a nearby creek and drown); Margaret Gibbons, *Nursing Home to Pay $650,000 in Settlement*, 221 LEGAL INTELLIGENCER S1 (1999) (relating a $650,000 settlement of a lawsuit filed by a widow of an eighty-year-old former mailman who wandered away from the nursing home and was found dead in a creek four days later); Lomento v. Doe Residential Care Facility, No. YC 029194, 1998 WL 953540 (Los Angeles Cty. Calif., settlement Jan. 1998) (noting a $97,500 settlement in case of an eighty-one-year-old nursing home resident with Alzheimer's disease and dementia who died after wandering away from the facility and drowning in a backyard swimming pool); Moss v. Persona Care West, JVR No. 177946, 1996 WL 386151 (Allegheny Cty. Penn; settlement May 1996) (reaching a $95,000 settlement in the case of an eighty-four-year-old nursing home resident who suffered a fractured hip, requiring replacement surgery, and hypothermia when she wandered

away from the facility during the winter and fell); Estate of Pierre v. Starlane Care Home et al., No. 717638, 1995 WL 856224 (Alameda Cty. Calif., settlement Aug. 1995) (reaching $65,000 settlement in case of an eighty-five-year-old resident suffering from extreme senility who drowned in a creek after he wandered away from the third-named defendant nursing home); Estate of Pouges v. Beverly Enters., Inc. Texas, d/b/a Clarksville Nursing Home, No. 348-CV-12-91, 1993 WL 763899 (Red River Cty. Tex., settlement Jan. 1993) (reaching a $400,000 settlement in the case of a resident with Alzheimer's disease who drowned in a six-inch puddle of water when he was left unattended and wandered off the premises); Estate of Beaulieu v. Coos Cty. Nursing Hosp., No. 90-C-92, 1992 WL 519398 (Coos Cty. N.H., settlement May 1992) (settling for $50,000 the case of an eighty-one-year-old nursing home resident with Alzheimer's disease who died after ingesting or aspirating cleaning fluid while wandering in the facility unattended).

6. *See, e.g.*, *Widow Sues Home Over Death*, DENVER ROCKY MOUNTAIN NEWS, Feb. 15, 2000, *available in* 2000 WL 6587152 (noting a woman's wrongful death suit against a nursing home which she claims let her ninety-three-year-old mentally ill husband wander outside and die of exposure to the cold in December 1999); *W. Pa Briefs*, ASSOCIATED PRESS NEWSWIRES, Jan. 31, 2000 (according to the coroner, a ninety-three-year-old woman found lying in the snow around 5:00 a.m. died of hypothermia after wandering away from a nursing home in cold weather and snow); *Fears for Missing Patient*, WESTERN DAILY PRESS, Dec. 21, 1999, *available in* 1999 WL 24871332 (describing a citywide police hunt for a confused elderly male nursing home resident in his seventies who wandered out of the facility on December 20, 1999, at 7:20 p.m. into severe weather conditions wearing only brown jogging bottoms, a blue long-sleeved T-shirt, and slippers); Estate of Klepitsch v. Seneca Nursing Home, JVR No. 71718, 1991 WL 450967 (Cook Cty. Ill., settlement July 1991) (agreeing to a $250,000 settlement in the matter of an eighty-three-year-old nursing home resident who died of hypothermia after wandering onto the facility's roof in the middle of winter); *cf.* Savage v. Beverly Enters. Texas, Inc., No. 12995, 1996 WL 641672 (Dallas Cty. Tex., Sept. 1996) (finding no negligence on the part of the nursing home where an eighty-four-year-old resident wandered away from the facility and froze to death).

7. Boyanton, *supra* note 5, at 5. *See, e.g.*, Joe Malinconico, *Firm Poised to Run Roosevelt Has Flawed Record*, STAR-LEDGER, Mar. 10, 2000, *available in* 2000 WL 15869201 ("[N]ursing home failed to monitor a man with dementia who wandered from the building and walked across a highway before being found a quarter mile away"); Trisha Renaud, *$1.5M OK'd for Patient Who Wandered, Was Hurt*, 110 FULTON CTY. DAILY REP., Feb. 16, 1999 (discussing $1.5 million dollar settlement reached in *Lee v. Tunstall Enterprises*, No. 96VSO119837J (Fult. St. filed Nov. 1, 1996), where a nursing home resident with Alzheimer's disease wandered away from the facility, was struck by a car, found injured miles from the home, and died two days later); Kevin Rothstein, *State Probes Train Death: Victim Was from Nursing Home*, PATRIOT LEDGER, Feb. 4, 2000, *available in* 2000 WL 9117274 (investigating death of fifty-seven-year-old nursing home resident struck and killed by a commuter train); Estate of Weber v. Sharon Health Care Elms, Inc., No. 92L-22, 1996 WL 1096020 (Peoria Cty. Ill., Feb. 1996) (awarding $137,371 to decedent's estate where eighty-three-year-old resident was found dead on the railroad tracks a day after he wandered away from the facility); Hamilton v. J&R Hill Corp. d/b/a House of Care, No. 9401-00469, 1994 WL 848498 (Multnomah Cty. Or., settlement Dec. 20, 1994) (contending that while driving at night, plaintiff struck and killed an elderly man who had wandered away from nursing home); Estate of O'Chall v. Lutheran Nursing Home, JVR No. 115936, 1992 WL 542036 (Cuyahoga Cty. Oh., settlement Nov. 1992) (reaching an $85,000 settlement in a case involving the death of a nursing home resident thirteen days after sustaining injuries when she wandered from the facility into the street and was struck by a vehicle); Estate of Garcia v. Arbor Care Ctr., JVR No. 67536, 1991 WL 445649 (Southern Dist. Cty. Tex. settlement Jan. 1991) (recognizing a $1,275,000 settlement in the case of an eighty-two-year-old nursing home resident with a history of wandering who died after he wandered away from the facility and was struck by a car).

8. *See, e.g.*, Daniels v. Twin Oaks Nursing Home, 692 F.2d 1321 (11th Cir. 1982), *reh'g denied*, 698 F.2d 1238 (11th Cir. 1983) (finding no negligence on the part of the facility where an eighty-year-old resident with a "persistent tendency to wander off" one day wandered out of nursing home and disappeared).

9. *See* Donna L. Algase, *Wandering in Dementia, in* 17 ANN. REV. NURSING RES. 185, 185 (Joyce J. Fitzpatrick ed., 1999).

10. *See id.* at 185–89 ("Wandering studies are plagued by missing or ambiguous definitions").

11. For example, "Many who wander are attempting to get to a former residence, workplace or city." Yvette Craig, *Alzheimer's Group Urges Use of Elderly I.D. Program Safe Return Designed to Address Danger of Wandering*, FORT WORTH STAR-TELEGRAM, Feb. 17, 2000, *available in* 2000 WL 4995422 (discussing "scared, confused and disoriented" sixty-nine-year-old man who suffers from dementia and had walked away from a nearby nursing home undetected); *see, e.g.*, Mason v. Southern Management Servs. d/b/a Highland Pines Nursing Manor, No. 90-6612-16, 1992 WL 737341 (Cir. Ct. Pinellas Cty. Fla., settled May 8, 1992) (describing how decedent wandered "out of the facility in an attempt to go home").

12. *See* Algase, *supra* note 9, at 188 (citing Donna L. Algase, *Cognitive Discriminants of Wandering among Nursing Home Residents*, 41 NURSING RESEARCH 78, 78–81 (1992) (characterizing wandering as occurring in large volume, that is at a high frequency, rate, or amount)); Pam Dawson & David W. Reid, *Behavioral Dimensions of Patients at Risk of Wandering*, 27 GERONTOLOGIST 104, 104–07 (1987); Richard A. Hussian & Debbie C. Brown, *Use of Two-Dimensional Grid Patterns to Limit Hazardous Ambulation in Demented Patients*, 42 J. GERONTOLOGY 558, 558–560 (1987); Kevan H. Namazi et al., *Visual Barriers to Prevent Ambulatory Alzheimer's Patients from Exiting through an Emergency Door*, 29 GERONTOLOGIST 699, 699–702 (1989); Andrew Satlin et al., *Circadian Locomotor Activity Rhythms in Alzheimer's Disease*, 5 NEUROPSYCHOPHARMACOLOGY 115, 115–26 (1991); Lorraine Hiatt Snyder et al., *Wandering*, 18 GERONTOLOGIST 272, 272–80 (1978).

13. Patricia W. Iyer, *Nursing Liability Issues, in* NURSING HOME LITIGATION: INVESTIGATION AND CASE PREPARATION 151, 170 (Patricia W. Iyer ed., 1999), (citing David W. Thomas, *Wandering: A Proposed Definition*, 21 J. GERONTOLOGICAL NURSING 35, 35–40 (Sept. 1995)).

14. *See* Algase, *supra* note 9, at 188, (citing Donna L. Algase et al., *Estimates of Stability of Daily Wandering Behavior among Cognitively Impaired Long-Term Care Residents*, 46 NURSING RESEARCH 172, 172–78 (1997)); *see, e.g.*, David W. Gilley et al., *Predictors of Behavioral Disturbance in Alzheimer's Disease*, 46 J. GERONTOLOGY 362, 362–371 (1991); Lucksri Hewawasam, *Floor Patterns Limit Wandering of People with Alzheimer's*, 92 NURSING TIMES 41, 41–44 (1996); David Martino-Saltzman et al., *Travel Behavior of Nursing Home Residents Perceived as Wanderers and Nonwanderers*, 31 GERONTOLOGIST 666, 666–72 (1991); Noel Monsour & Susanne S. Robb, *Wandering Behavior in Old Age: A Psychosocial Study*, 27 SOCIAL WORK 411, 411–16 (1982); Dan Mungas et al., *Assessment of Disruptive Behavior Associated with Dementia: The Disruptive Behavior Rating Scales*, 2 J. GERIATRIC PSYCHIATRY & NEUROLOGY 196, 196–202 (1989); Snyder et al., *supra* note 12, at 272–80.

15. *See* Algase, *supra* note 9, at 188 (citing Paul K. Chafetz, *Two-Dimensional Grid Is Ineffective against Demented Patients Exiting through Glass Doors*, 5 PSYCHOLOGY & AGING 146, 146–147 (1990)); *see, e.g.*, John Cumming et al., *The Episodic Nature of Behavioral Disturbances among Residents of Facilities for the Aged* 73 CAN. J. PUB. HEALTH 319, 319–322 (1982); Jerry H. Gurwitz et al., *The Epidemiology of Adverse and Unexpected Events in the Long-Term Care Setting*, 42 J. AM. GERIATRICS SOC'Y 33, 33–38 (1994); Hussian & Brown, *supra* note 12, at 58–60; Jen-Ping Hwang et al., *Behavioral Disturbances in Psychiatric Inpatients with Dementia of the Alzheimer's Type in Taiwan*, 12 INT'L J. GERIATRIC PSYCHIATRY 902, 902–06 (1997); Emoeke Jozsavi et al., *Behavior Management of a Patient with Creutzfeld-Jacob Disease*, 16 CLINICAL GERONTOLOGIST 11, 11–17 (1996); Mungas, *supra* note 14, at 196–202.

16. *See* Algase, *supra* note 9, at 188 (citing Clive G. Ballard et al., *Wandering in Dementia Sufferers*, 6 INT'L J. GERIATRIC PSYCHIATRY 611, 611–14 (1991)); *see, e.g.*, Victor Henderson et al., *Spatial Disorientation in Alzheimer's Disease*, 46 ARCHIVES NEUROLOGY 391, 391–94 (1989); Richard A. Hussian, *Stimulus Control in the Modification of Problematic Behavior in Elderly Institutionalized Patients* 1 INT'L J. BEHAV. GERIATRICS 47, 47–51 (1982); Hwang, *supra* note 15, at 902–06; Li Li Liu et al., *Spatial Disorientation in Persons with Early Senile Dementia of the Alzheimer Type*, 45 AM. J. OCCUPATIONAL THERAPY 67, 67–74 (1991); Monsour & Robb, *supra* note 14, at 411–16; Mungas, *supra* note 14, at 196–202.

17. *See* REIN TIDEIKSAAR, FALLS IN OLDER PERSONS: PREVENTION AND MANAGEMENT IN HOSPITALS AND NURSING HOMES 28 (1993).

18. *See* Algase, *supra* note 9, at 196–97.

19. *See id.* at 197.

20. *See* Ralph Gerstein, *Nursing Home Litigation, in* THE ELDER LAW PORTFOLIO SERIES §13–10.6 (Feb. 1996) (discussing injury to a resident who wanders away from the nursing home).

21. *See* Boyanton, *supra* note 5, at 5.

22. 674 S.W.2d 343 (Tex. Ct. App. 1984).

23. *See* ERIC M. CARLSON, LONG-TERM CARE ADVOCACY § 10.11[2] (1999) (discussing *Golden Villa Nursing Home v. Smith*); *see, e.g.*, Kira Anne Larson, Note, *Nursing Homes: Standards of Care, Sources of Potential Liability, Defenses to Suit, and Reform*, 37 DRAKE L. REV. 699, 715–16 (1987/1988) (discussing same).

24. *See* Golden Villa, 674 S.W.2d at 346.

25. 483 So. 2d 634 (La. Ct. App. 1985).

26. *See id.* at 638–39.

27. 528 So. 2d 573, 580 (La. Ct. App. 1988).

28. 493 So. 2d 819, 821-23 (La. Ct. App. 1986).

29. *Id.* at 820–821.

30. *Id.* at 823 (emphasis added).

31. 295 So. 2d 29, 34–36 (La. Ct. App. 1974).

32. 42 C.F.R. § 483.20(b)(2)(i).

33. 42 C.F.R. § 483.20(b)(2)(iii).

34. 42 C.F.R. § 483.20(b)(2)(ii).

35. *See generally*, Patricia W. Iyer, *Foundations of Nursing Practice, in* NURSING HOME LITIGATION: INVESTIGATION AND CASE PREPARATION 37, 54-55, 57-59 (Patricia W. Iyer ed., 1999) (documenting specific aspects of resident assessment such as wandering behavior and reviewing resident assessment protocol as well as quarterly and annual resident reassessments).

36. *See* 42 C.F.R. § 483.20(k)2)(i).

37. *See* 42 C.F.R. § 483.20(k)(2)(ii) (listing members of the interdisciplinary team).

38. 42 C.F.R. § 483.20(k)(1).

39. *See* 42 C.F.R. § 483.20(k)(2)(iii).

40. 42 C.F.R. § 483.20(k)(i).

41. 42 C.F.R. §483.15(f)(1).

42. *See, e.g.*, Katherin Heard & T. Steuart Watson, *Reducing Wandering by Persons with Dementia Using Differential Reinforcement*, 32 J. APPLIED BEHAV. ANALYSIS 381, 381–384 (Fall 1999) (using differential reinforcement of other behavior significantly reduces wandering); Myra A. Shneider, *What to Do for Wandering*, 17 CARING 40, 40–41 (July 1998) (offering common-sense tips to help providers and family caregivers manage wandering behavior); Jiska Cohen-Mansfield & Perla Werner, *The Effects of an Enhanced Environment on Nursing Home Residents Who Pace*, 38 GERONTOLOGIST 199, 199–208 (Apr. 1998) (enriching the nursing home environment for residents who pace and wander with visual, auditory, and olfactory stimuli decreases, among other behaviors, exit-seeking); Sharon K. Holmberg, *Evaluation of a Clinical Intervention for Wanders on a Geriatric Nursing Unit*, 11 ARCHIVES PSYCHIATRIC NURSING 21, 21–28 (Feb. 1997) (decreasing unsafe wandering on a geriatric nursing unit through a walking program); Will Coltharp Jr. et al., *Wandering*, 22 J. GERONTOLOGICAL NURSING 5, 5–10 (Nov. 1996) (managing the environment is the best means of dealing with wandering behavior with medication as the intervention of last choice). *See generally* Mary Ann Anderson et al., *Entering the World of Dementia: CAN Interventions for Nursing Home Residents*, 24 J. GERONTOLOGICAL NURSING 31, 31–37 (Nov. 1998).

43. *See* Dennis C. Donat, *Modifying Wandering Behavior: A Case Study*, 3 CLINICAL GERONTOLOGIST 41, 41–43 (1984); *see generally* Rebecca Allen-Burge et al., *Effective Behavioral Interventions for Decreasing Dementia-Related Challenging Behavior in Nursing Homes*, 14 INT'L J. GERIATRIC PSYCHIATRY 213, 213–228 (Mar. 1999) (reviewing behavioral intervention research aimed at decreasing wandering behavior among nursing home residents).

44. 42 C.F.R. § 483.25(h)(1) & (2).

45. *See* Byron S. Arbeit, *The Administrator and Nursing Home Liability Issues, in* NURSING HOME LITIGATION: INVESTIGATION AND CASE PREPARATION 111, 135–36 (Patricia W. Iyer ed., 1999) (applying 42 C.F.R. § 483.25(h) to cases dealing with, among other subjects, "[m]obile, confused-to-location residents who elope").

46. *See* Timothy Howell, *Emotional and Behavioral Problems, in* DUTHIE: PRACTICE OF GERIATRICS 295, 296 (3d ed. 1998) ("[W]andering in a street would be considered risky, whereas wandering in a safe yard could even be beneficial").

47. *See* Algase, *supra* note 9, at 205–206; *see, e.g.*, Joan I. Dickinson & Joan Mclain-Kark, *Wandering Behavior and Attempted Exits among Residents Diagnosed with Dementia-Related Illnesses: A Qualitative Approach*, 10 J. WOMEN AGING 23, 23–34 (1998) (investigating exiting attempts and wandering behavior by exposing residents to a mini-blind that concealed the view from the door and a cloth panel that concealed the panic bar of the door); *Physical Restraints*, CONTINUING CARE RISK MANAGEMENT 1, 22 (ECRI Sept. 1995) (suggesting alternatives to physical restraints that decrease the risks associated with resident wandering).

48. *See* Iyer, *supra* note 13, at 152.

49. *See, e.g.* Philip D. Sloane, *Environmental Correlates of Resident Agitation in Alzheimer's Disease Special Care*, 46 J. AM. GERIATRICS SOC'Y 862, 862–869 (July 1998).

50. *See, e.g.*, CODE ME. R. § 10-144-110, 23 (1999) (detailing requirements for Alzheimer's dementia care units located within nursing homes); TENN. COMP. R. & REGS. tit. 17, ch. 1200-8-6-.10 (1999) (describing additional requirements for a part of the nursing home designated as an Alzheimer's special care unit).

51. *See, e.g.*, Tom Joyce, *Nursing Home Hit with Fine. The State also Has Reduced the Woodland Center for Nursing's License to Provisional Status until Aug. 1*, N.Y. DAILY RECORD, Mar. 15, 2000, at C; 01, *available in* 2000 WL 9759907 (noting that the state department of health fined a nursing facility $15,400 after finding multiple reports of residents wandering outside the facility without supervision); Tom Joyce, *Woodland Patients in Jeopardy. A Woman Who Wandered into the Snow and Died Had Wandered out of the Building Several Times Before*, N.Y. DAILY RECORD, Feb. 19, 2000, at A; 03, *available in* 2000 WL 9759051.

52. *See* Apple Investment Properties, Inc. v. Watts, 469 S.E.2d 356, 357 (Ga. Ct. App. 1996).

53. *Id.* at 358.

54. *State Says Epsom Manor Violations Continue*, ASSOCIATED PRESS, Mar. 21, 2000.

55. *See, e.g.*, Daniel B. Kennedy, *Precautions for the Physical Security of the Wandering Patient*, 4 SECURITY J. 170, 170 (Oct. 1993).

56. *See* Mary L. Lubin, *Inside the Nursing Home: The Structure, in* NURSING HOME LITIGATION: INVESTIGATION AND CASE PREPARATION 13, 34 (Patricia W. Iyer ed., 1999).

57. 483 So. 2d 634 (La. Ct. App. 1985).

58. 528 So. 2d 573 (La. Ct. App. 1988).

59. 902 F.2d 582 (7th Cir. 1990).

60. *Id.* at 583.

61. *See, e.g.*, Booty, 483 So. 2d at 639 ("However, solely for the convenience of the staff, [the nursing home] kept the exit doors propped open until 11:00 p.m., thus rendering the alarm system useless").

62. *See* Elizabeth A. Capezuti & William T. Lawson, III, *Falls and Restraints—Liability Issues, in* NURSING HOME LITIGATION: INVESTIGATION AND CASE PREPARATION 205, 215–16 (Patricia W. Iyer ed., 1999), (citing Bettye Rose Connell, *Role of the Environment in Falls Prevention*, 12 CLINICS IN GERIATRIC MED. 859, 859–880 (1996) and J. A. Sanford et al., *Alarm System Technology in Elopement Prevention*, 2 TECHNOLOGY & DISABILITY 22, 22–33 (1993)).

63. 198 F.3d 251 (8th Cir. 1999).

64. *See Verdicts & Settlements* 20 NAT'L L. J. Apr. 27, 1998, at A13 (col. 3) (discussing *Ragle v. Beverly Enterprises, Inc.*).

65. *See id.*

66. *See id.*

67. *See id.*

68. *See* Ragle, 198 F.3d at 251.

69. No. CL97-1621 (Cir. Ct. Palm Beach Cty. Fla., Feb. 11, 1998).

70. Donald C. Dilworth, *Negligent Nursing Home Care Triggers Juror Outrage*, 34 TRIAL 16, 16 (Aug. 1998) (discussing *Hamilton v. First Healthcare Corp.*).

71. *See id.* at 16.

72. Gail Diane Cox, *Suits Alleging Abuse or Wrongful Death of Nursing Care Patients Draw Big Settlements and Awards*, 20 NAT'L L. J., Mar. 2, 1998, at A1 (col. 2) (discussing *Hamilton v. First Healthcare Corp.*).

73. *See id.*

74. *See* Estate of Spratt v. Health Enters. of Mich., Inc., No. 96-5129, 1997 WL 544916 (Arenac Cty. Mich., settlement Jan. 1997).

75. *See generally* TIDEIKSAAR, *supra* note 17, at 122–26 (highlighting alarm systems and providing contact information for their manufacturers).

76. *See id.* at 123.

77. *See id.* at 122, 125.

78. *See id.* at 124.

79. *See id.* at 126.

80. *See* Joyce, *supra* note 51.

81. Tom Joyce, *Woodland Patients in Jeopardy, supra* note 51.

82. *See* Joyce, *supra* note 51.

83. *See id.*

84. No. CV-94-136, 1995 WL 725784 (Crawford Cty. Ark., Apr. 1995).

85. *Id.* at *1.

86. *See, e.g., EXI Wireless Systems Inc. Appointed Sole Supplier of Patient and Infant Protection Systems by Simplex*, CANADA NEWS WIRE, Mar. 21, 2000 (discussing the sale, installation, and support for Roam Alert, a protection system that assists in monitoring the wanderings of people suffering from illnesses such as Alzheimer's disease).

87. 481 So. 2d 1126 (Ala. 1985).

88. *See id* at 1126.